

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037178

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 282 Primary Registration District No. 5948 Registrar's No. 129

FILED OCT 11 1963

1. PLACE OF DEATH a. COUNTY POIK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY POIK	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Goodson Benton Twp.		c. CITY OR TOWN Goodson Mo.	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Home		d. STREET ADDRESS (If outside, give location) Home	
3. NAME OF DECEASED (Type or print) CYNTHIA ZORA ANN PIPER		4. DATE OF DEATH Month Oct Day 6 Year 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-9-1887
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home MAHER	11. BIRTHPLACE (City and state or country) KENTUCKY
13a. FATHER'S NAME J.D. GRIFFIN		13b. MOTHER'S MAIDEN NAME SARAH MEEK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) No		17. INFORMANT Cora A. Breshears, Goodson, Mo	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <input type="checkbox"/> Month, Day, Year <input type="checkbox"/>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from Sept 5, 1963 to 6 Oct 63 and last saw her alive on 27 Sep 63 Death occurred at 8:09 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Dr. W. D. Payne		22b. ADDRESS Payne Cemetery	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 9, 1963	
23c. NAME OF CEMETERY OR CREMATORY Payne Cemetery		23d. LOCATION (City, town, or county) POIK Mo	
24. FUNERAL DIRECTOR Libney G. Pitts, Bolivar, Mo.		25. DATE RECD. BY LOCAL REG. Oct. 8, 1963	
26. REGISTRAR'S SIGNATURE Ralph Gordon per J.H.			

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

USE BLACK INK
OR
TYPEWRITER RIBBONVS 300
Rev. 4/59

DATE AMENDED

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2 0840

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12 90-0

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Permit issued Oct. 8, 1963 J.R.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Madison J. Pitts

Licensed Embalmer No. 4939

P. O. Address Bolivar, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.